CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Los Angeles, San Bernardino and Riverside.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Anthem Blue Cross Select HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	841.13	388.21	74.10	34.20	915.23	422.41	721.23	332.88	194.00	89.54
	Employee only (FT) w/Delta Care Dental HMO	841.13	388.21	15.12	6.98	856.25	395.19	721.23	332.88	135.02	62.32
	Employee only (Ben PT) w/Delta Dental Premier	841.13	388.21	74.10	34.20	915.23	422.41	721.23	332.88	194.00	89.54
	Employee only (Ben PT) w/Delta Care Dental HMO	841.13	388.21	15.12	6.98	856.25	395.19	721.23	332.88	135.02	62.32
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,682.26	776.43	127.61	58.90	1,809.87	835.32	1,342.43	619.58	467.44	215.74
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,682.26	776.43	27.17	12.54	1,709.43	788.97	1,342.43	619.58	367.00	169.38
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,682.26	776.43	127.61	58.90	1,809.87	835.32	721.23	332.88	1,088.64	502.45
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,682.26	776.43	27.17	12.54	1,709.43	788.97	721.23	332.88	988.20	456.09
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,186.94	1,009.36	192.66	88.92	2,379.60	1,098.28	1,779.13	821.14	600.47	277.14
	Family Coverage (FT) w/Delta Care Dental HMO	2,186.94	1,009.36	40.19	18.55	2,227.13	1,027.91	1,779.13	821.14	448.00	206.77
	Family Coverage (Ben PT) w/Delta Dental Premier	2,186.94	1,009.36	192.66	88.92	2,379.60	1,098.28	721.23	332.88	1,658.37	765.40
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,186.94	1,009.36	40.19	18.55	2,227.13	1,027.91	721.23	332.88	1,505.90	695.03
	Anthem Blue Cross Traditional HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	1,012.67	467.39	74.10	34.20	1,086.77	501.59	721.23	332.88	365.54	168.71
	Employee only (FT) w/Delta Care Dental HMO	1,012.67	467.39	15.12	6.98	1,027.79	474.36	721.23	332.88	306.56	141.49
	Employee only (Ben PT) w/Delta Dental Premier	1,012.67	467.39	74.10	34.20	1,086.77	501.59	721.23	332.88	365.54	168.71
	Employee only (Ben PT) w/Delta Care Dental HMO	1,012.67	467.39	15.12	6.98	1,027.79	474.36	721.23	332.88	306.56	141.49
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	2,025.34	934.77	127.61	58.90	2,152.95	993.67	1,342.43	619.58	810.52	374.09
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	2,025.34	934.77	28.59	13.20	2,053.93	947.97	1,342.43	619.58	711.50	328.38
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	2,025.34	934.77	127.61	58.90	2,152.95	993.67	721.23	332.88	1,431.72	660.79
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	2,025.34	934.77	28.59	13.20	2,053.93	947.97	721.23	332.88	1,332.70	615.09
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,632.94	1,215.20	192.66	88.92	2,825.60	1,304.12	1,779.13	821.14	1,046.47	482.99
	Family Coverage (FT) w/Delta Care Dental HMO	2,632.94	1,215.20	40.19	18.55	2,673.13	1,233.75	1,779.13	821.14	894.00	412.62
	Family Coverage (Ben PT) w/Delta Dental Premier	2,632.94	1,215.20	192.66	88.92	2,825.60	1,304.12	721.23	332.88	2,104.37	971.25
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,632.94	1,215.20	40.19	18.55	2,673.13	1,233.75	721.23	332.88	1,951.90	900.88
	Blue Shield Access + HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	756.65	349.22	74.10	34.20	830.75	383.42	721.23	332.88	109.52	50.55
	Employee only (FT) w/Delta Care Dental HMO	756.65	349.22	15.12	6.98	771.77	356.20	721.23	332.88	50.54	23.33
	Employee only (Ben PT) w/Delta Dental Premier	756.65	349.22	74.10	34.20	830.75	383.42	721.23	332.88	109.52	50.55
	Employee only (Ben PT) w/Delta Care Dental HMO	756.65	349.22	15.12	6.98	771.77	356.20	721.23	332.88	50.54	23.33
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,513.30	698.45	127.61	58.90	1,640.91	757.34	1,342.43	619.58	298.48	137.76
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,513.30	698.45	27.17	12.54	1,540.47	710.99	1,342.43	619.58	198.04	91.40
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,513.30	698.45	127.61	58.90	1,640.91	757.34	721.23	332.88	919.68	424.47
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,513.30	698.45	27.17	12.54	1,540.47	710.99	721.23	332.88	819.24	378.11
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	1,967.29	907.98	192.66	88.92	2,159.95	996.90	1,779.13	821.14	380.82	175.76
	Family Coverage (FT) w/Delta Care Dental HMO	1,967.29	907.98	40.19	18.55	2,007.48	926.53	1,779.13	821.14	228.35	105.39
	Family Coverage (Ben PT) w/Delta Dental Premier	1,967.29	907.98	192.66	88.92	2,159.95	996.90	721.23	332.88	1,438.72	664.02
	Family Coverage (Ben PT) w/Delta Care Dental HMO	1,967.29	907.98	40.19	18.55	2,007.48	926.53	721.23	332.88	1,286.25	593.65

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Los Angeles, San Bernardino and Riverside.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Blue Shield Trio HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	704.69	325.24	74.10	34.20	778.79	359.44	721.23	332.88	57.56	26.57
	Employee only (FT) w/Delta Care Dental HMO	704.69	325.24	15.12	6.98	719.81	332.22	721.23	332.88	-1.42	-0.66
	Employee only (Ben PT) w/Delta Dental Premier	704.69	325.24	74.10	34.20	778.79	359.44	721.23	332.88	57.56	26.57
	Employee only (Ben PT) w/Delta Care Dental HMO	704.69	325.24	15.12	6.98	719.81	332.22	721.23	332.88	-1.42	-0.66
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,409.38	650.48	127.61	58.90	1,536.99	709.38	1,342.43	619.58	194.56	89.80
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,409.38	650.48	27.17	12.54	1,436.55	663.02	1,342.43	619.58	94.12	43.44
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,409.38	650.48	127.61	58.90	1,536.99	709.38	721.23	332.88	815.76	376.50
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,409.38	650.48	27.17	12.54	1,436.55	663.02	721.23	332.88	715.32	330.15
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	1,832.19	845.63	192.66	88.92	2,024.85	934.55	1,779.13	821.14	245.72	113.41
	Family Coverage (FT) w/Delta Care Dental HMO	1,832.19	845.63	40.19	18.55	1,872.38	864.18	1,779.13	821.14	93.25	43.04
	Family Coverage (Ben PT) w/Delta Dental Premier	1,832.19	845.63	192.66	88.92	2,024.85	934.55	721.23	332.88	1,303.62	601.67
	Family Coverage (Ben PT) w/Delta Care Dental HMO	1,832.19	845.63	40.19	18.55	1,872.38	864.18	721.23	332.88	1,151.15	531.30
	Health Net Salud y Mas HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	630.13	290.83	74.10	34.20	704.23	325.03	721.23	332.88	-17.00	-7.85
	Employee only (FT) w/Delta Care Dental HMO	630.13	290.83	15.12	6.98	645.25	297.81	721.23	332.88	-75.98	-35.07
	Employee only (Ben PT) w/Delta Dental Premier	630.13	290.83	74.10	34.20	704.23	325.03	721.23	332.88	-17.00	-7.85
	Employee only (Ben PT) w/Delta Care Dental HMO	630.13	290.83	15.12	6.98	645.25	297.81	721.23	332.88	-75.98	-35.07
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,260.26	581.66	127.61	58.90	1,387.87	640.56	1,342.43	619.58	45.44	20.97
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,260.26	581.66	27.17	12.54	1,287.43	594.20	1,342.43	619.58	-55.00	-25.38
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,260.26	581.66	127.61	58.90	1,387.87	640.56	721.23	332.88	666.64	307.68
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,260.26	581.66	27.17	12.54	1,287.43	594.20	721.23	332.88	566.20	261.32
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	1,638.34	756.16	192.66	88.92	1,831.00	845.08	1,779.13	821.14	51.87	23.94
	Family Coverage (FT) w/Delta Care Dental HMO	1,638.34	756.16	40.19	18.55	1,678.53	774.71	1,779.13	821.14	-100.60	-46.43
	Family Coverage (Ben PT) w/Delta Dental Premier	1,638.34	756.16	192.66	88.92	1,831.00	845.08	721.23	332.88	1,109.77	512.20
	Family Coverage (Ben PT) w/Delta Care Dental HMO	1,638.34	756.16	40.19	18.55	1,678.53	774.71	721.23	332.88	957.30	441.83

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Los Angeles, San Bernardino and Riverside.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Kaiser Permanente California HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	865.41	399.42	74.10	34.20	939.51	433.62	721.23	332.88	218.28	100.74
	Employee only (FT) w/Delta Care Dental HMO	865.41	399.42	15.12	6.98	880.53	406.40	721.23	332.88	159.30	73.52
	Employee only (Ben PT) w/Delta Dental Premier	865.41	399.42	74.10	34.20	939.51	433.62	721.23	332.88	218.28	100.74
	Employee only (Ben PT) w/Delta Care Dental HMO	865.41	399.42	15.12	6.98	880.53	406.40	721.23	332.88	159.30	73.52
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,730.82	798.84	127.61	58.90	1,858.43	857.74	1,342.43	619.58	516.00	238.15
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,730.82	798.84	27.17	12.54	1,757.99	811.38	1,342.43	619.58	415.56	191.80
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,730.82	798.84	127.61	58.90	1,858.43	857.74	721.23	332.88	1,137.20	524.86
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,730.82	798.84	27.17	12.54	1,757.99	811.38	721.23	332.88	1,036.76	478.50
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,250.07	1,038.49	192.66	88.92	2,442.73	1,127.41	1,779.13	821.14	663.60	306.28
	Family Coverage (FT) w/Delta Care Dental HMO	2,250.07	1,038.49	40.19	18.55	2,290.26	1,057.04	1,779.13	821.14	511.13	235.91
	Family Coverage (Ben PT) w/Delta Dental Premier	2,250.07	1,038.49	192.66	88.92	2,442.73	1,127.41	721.23	332.88	1,721.50	794.54
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,250.07	1,038.49	40.19	18.55	2,290.26	1,057.04	721.23	332.88	1,569.03	724.17
	PERS Gold PPO										
Employee Only	Employee only (FT) w/Delta Dental Premier	785.28	362.44	74.10	34.20	859.38	396.64	721.23	332.88	138.15	63.76
	Employee only (FT) w/Delta Care Dental HMO	785.28	362.44	15.12	6.98	800.40	369.42	721.23	332.88	79.17	36.54
	Employee only (Ben PT) w/Delta Dental Premier	785.28	362.44	74.10	34.20	859.38	396.64	721.23	332.88	138.15	63.76
	Employee only (Ben PT) w/Delta Care Dental HMO	785.28	362.44	15.12	6.98	800.40	369.42	721.23	332.88	79.17	36.54
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,570.56	724.87	127.61	58.90	1,698.17	783.77	1,342.43	619.58	355.74	164.19
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,570.56	724.87	27.17	12.54	1,597.73	737.41	1,342.43	619.58	255.30	117.83
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,570.56	724.87	127.61	58.90	1,698.17	783.77	721.23	332.88	976.94	450.90
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,570.56	724.87	27.17	12.54	1,597.73	737.41	721.23	332.88	876.50	404.54
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,041.73	942.34	192.66	88.92	2,234.39	1,031.26	1,779.13	821.14	455.26	210.12
	Family Coverage (FT) w/Delta Care Dental HMO	2,041.73	942.34	40.19	18.55	2,081.92	960.89	1,779.13	821.14	302.79	139.75
	Family Coverage (Ben PT) w/Delta Dental Premier	2,041.73	942.34	192.66	88.92	2,234.39	1,031.26	721.23	332.88	1,513.16	698.38
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,041.73	942.34	40.19	18.55	2,081.92	960.89	721.23	332.88	1,360.69	628.01
	PERS Platinum PPO										
Employee Only	Employee only (FT) w/Delta Dental Premier	1,131.47	522.22	74.10	34.20	1,205.57	556.42	721.23	332.88	484.34	223.54
	Employee only (FT) w/Delta Care Dental HMO	1,131.47	522.22	15.12	6.98	1,146.59	529.20	721.23	332.88	425.36	196.32
	Employee only (Ben PT) w/Delta Dental Premier	1,131.47	522.22	74.10	34.20	1,205.57	556.42	721.23	332.88	484.34	223.54
	Employee only (Ben PT) w/Delta Care Dental HMO	1,131.47	522.22	15.12	6.98	1,146.59	529.20	721.23	332.88	425.36	196.32
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	2,262.94	1,044.43	127.61	58.90	2,390.55	1,103.33	1,342.43	619.58	1,048.12	483.75
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	2,262.94	1,044.43	27.17	12.54	2,290.11	1,056.97	1,342.43	619.58	947.68	437.39
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	2,262.94	1,044.43	127.61	58.90	2,390.55	1,103.33	721.23	332.88	1,669.32	770.46
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	2,262.94	1,044.43	27.17	12.54	2,290.11	1,056.97	721.23	332.88	1,568.88	724.10
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,941.82	1,357.76	192.66	88.92	3,134.48	1,446.68	1,779.13	821.14	1,355.35	625.55
	Family Coverage (FT) w/Delta Care Dental HMO	2,941.82	1,357.76	40.19	18.55	2,982.01	1,376.31	1,779.13	821.14	1,202.88	555.18
	Family Coverage (Ben PT) w/Delta Dental Premier	2,941.82	1,357.76	192.66	88.92	3,134.48	1,446.68	721.23	371.11	2,413.25	1,075.57
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,941.82	1,357.76	40.19	18.55	2,982.01	1,376.31	721.23	371.11	2,260.78	1,005.20

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Los Angeles, San Bernardino and Riverside.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	United Healthcare Signature Alliance HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	826.44	381.43	74.10	34.20	900.54	415.63	721.23	332.88	179.31	82.76
	Employee only (FT) w/Delta Care Dental HMO	826.44	381.43	15.12	6.98	841.56	388.41	721.23	332.88	120.33	55.54
	Employee only (Ben PT) w/Delta Dental Premier	826.44	381.43	74.10	34.20	900.54	415.63	721.23	332.88	179.31	82.76
	Employee only (Ben PT) w/Delta Care Dental HMO	826.44	381.43	15.12	6.98	841.56	388.41	721.23	332.88	120.33	55.54
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,652.88	762.87	127.61	58.90	1,780.49	821.76	1,342.43	619.58	438.06	202.18
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,652.88	762.87	27.17	12.54	1,680.05	775.41	1,342.43	619.58	337.62	155.82
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,652.88	762.87	127.61	58.90	1,780.49	821.76	721.23	332.88	1,059.26	488.89
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,652.88	762.87	27.17	12.54	1,680.05	775.41	721.23	332.88	958.82	442.53
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,148.74	991.73	192.66	88.92	2,341.40	1,080.65	1,779.13	821.14	562.27	259.51
	Family Coverage (FT) w/Delta Care Dental HMO	2,148.74	991.73	40.19	18.55	2,188.93	1,010.28	1,779.13	821.14	409.80	189.14
	Family Coverage (Ben PT) w/Delta Dental Premier	2,148.74	991.73	192.66	88.92	2,341.40	1,080.65	721.23	332.88	1,620.17	747.77
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,148.74	991.73	40.19	18.55	2,188.93	1,010.28	721.23	332.88	1,467.70	677.40
	United Healthcare Signature Harmony HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	734.76	339.12	74.10	34.20	808.86	373.32	721.23	332.88	87.63	40.44
	Employee only (FT) w/Delta Care Dental HMO	734.76	339.12	15.12	6.98	749.88	346.10	721.23	332.88	28.65	13.22
	Employee only (Ben PT) w/Delta Dental Premier	734.76	339.12	74.10	34.20	808.86	373.32	721.23	332.88	87.63	40.44
	Employee only (Ben PT) w/Delta Care Dental HMO	734.76	339.12	15.12	6.98	749.88	346.10	721.23	332.88	28.65	13.22
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,469.52	678.24	127.61	58.90	1,597.13	737.14	1,342.43	619.58	254.70	117.55
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,469.52	678.24	27.17	12.54	1,496.69	690.78	1,342.43	619.58	154.26	71.20
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,469.52	678.24	127.61	58.90	1,597.13	737.14	721.23	332.88	875.90	404.26
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,469.52	678.24	27.17	12.54	1,496.69	690.78	721.23	332.88	775.46	357.90
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	1,910.38	881.71	192.66	88.92	2,103.04	970.63	1,779.13	821.14	323.91	149.50
	Family Coverage (FT) w/Delta Care Dental HMO	1,910.38	881.71	40.19	18.55	1,950.57	900.26	1,779.13	821.14	171.44	79.13
	Family Coverage (Ben PT) w/Delta Dental Premier	1,910.38	881.71	192.66	88.92	2,103.04	970.63	721.23	332.88	1,381.81	637.76
	Family Coverage (Ben PT) w/Delta Care Dental HMO	1,910.38	881.71	40.19	18.55	1,950.57	900.26	721.23	332.88	1,229.34	567.39

Notes:
1) Employees can opt out of dental coverage and receive the balance of the Cafeteria Plan amount.
2) Married Employees opt out rebate: FT $80.77/pay period, Benefited Part-Time.
3) Rebate for opting out of Medical for FT Employees is $300/month ($138.46 biweekly); for Benefited Part-time $100/month ($46.15 biweekly). Employee must remain in Vision.
4) Rebate for opting out of medical and dental for FT Employees is $315.93/month ($145.81 biweekly); for Benefited Part-time $115.93/month ($53.50 biweekly). Employee must remain in Vision.
5) There are 26 pay periods per year.
6) The rates listed on this sheet do not include the VSP Vision costs as these are City-paid and not part of the Cafeteria Plan.

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Orange, San Diego, and Imperial.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Anthem Blue Cross Select HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	807.71	372.79	74.10	34.20	881.81	406.99	721.23	332.88	160.58	74.11
	Employee only (FT) w/Delta Care Dental HMO	807.71	372.79	15.12	6.98	822.83	379.77	721.23	332.88	101.60	46.89
	Employee only (Ben PT) w/Delta Dental Premier	807.71	372.79	74.10	34.20	881.81	406.99	721.23	332.88	160.58	74.11
	Employee only (Ben PT) w/Delta Care Dental HMO	807.71	372.79	15.12	6.98	822.83	379.77	721.23	332.88	101.60	46.89
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,615.42	745.58	127.61	58.90	1,743.03	804.48	1,342.43	619.58	400.60	184.89
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,615.42	745.58	27.17	12.54	1,642.59	758.12	1,342.43	619.58	300.16	138.54
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,615.42	745.58	127.61	58.90	1,743.03	804.48	721.23	332.88	1,021.80	471.60
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,615.42	745.58	27.17	12.54	1,642.59	758.12	721.23	332.88	921.36	425.24
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,100.05	969.25	192.66	88.92	2,292.71	1,058.17	1,779.13	821.14	513.58	237.04
	Family Coverage (FT) w/Delta Care Dental HMO	2,100.05	969.25	40.19	18.55	2,140.24	987.80	1,779.13	821.14	361.11	166.67
	Family Coverage (Ben PT) w/Delta Dental Premier	2,100.05	969.25	192.66	88.92	2,292.71	1,058.17	721.23	332.88	1,571.48	725.30
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,100.05	969.25	40.19	18.55	2,140.24	987.80	721.23	332.88	1,419.01	654.93
	Anthem Blue Cross Traditional HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	1,034.38	477.41	74.10	34.20	1,108.48	511.61	721.23	332.88	387.25	178.73
	Employee only (FT) w/Delta Care Dental HMO	1,034.38	477.41	15.12	6.98	1,049.50	484.38	721.23	332.88	328.27	151.51
	Employee only (Ben PT) w/Delta Dental Premier	1,034.38	477.41	74.10	34.20	1,108.48	511.61	721.23	332.88	387.25	178.73
	Employee only (Ben PT) w/Delta Care Dental HMO	1,034.38	477.41	15.12	6.98	1,049.50	484.38	721.23	332.88	328.27	151.51
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	2,068.76	954.81	127.61	58.90	2,196.37	1,013.71	1,342.43	619.58	853.94	394.13
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	2,068.76	954.81	27.17	12.54	2,095.93	967.35	1,342.43	619.58	753.50	347.77
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	2,068.76	954.81	127.61	58.90	2,196.37	1,013.71	721.23	332.88	1,475.14	680.83
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	2,068.76	954.81	27.17	12.54	2,095.93	967.35	721.23	332.88	1,374.70	634.48
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,689.39	1,241.26	192.66	88.92	2,882.05	1,330.18	1,779.13	821.14	1,102.92	509.04
	Family Coverage (FT) w/Delta Care Dental HMO	2,689.39	1,241.26	40.19	18.55	2,729.58	1,259.81	1,779.13	821.14	950.45	438.67
	Family Coverage (Ben PT) w/Delta Dental Premier	2,689.39	1,241.26	192.66	88.92	2,882.05	1,330.18	721.23	332.88	2,160.82	997.30
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,689.39	1,241.26	40.19	18.55	2,729.58	1,259.81	721.23	332.88	2,008.35	926.93
	Blue Shield Access + HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	869.14	401.14	74.10	34.20	943.24	435.34	721.23	332.88	222.01	102.47
	Employee only (FT) w/Delta Care Dental HMO	869.14	401.14	15.12	6.98	884.26	408.12	721.23	332.88	163.03	75.24
	Employee only (Ben PT) w/Delta Dental Premier	869.14	401.14	74.10	34.20	943.24	435.34	721.23	332.88	222.01	102.47
	Employee only (Ben PT) w/Delta Care Dental HMO	869.14	401.14	15.12	6.98	884.26	408.12	721.23	332.88	163.03	75.24
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,738.28	802.28	127.61	58.90	1,865.89	861.18	1,342.43	619.58	523.46	241.60
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,738.28	802.28	27.17	12.54	1,765.45	814.82	1,342.43	619.58	423.02	195.24
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,738.28	802.28	127.61	58.90	1,865.89	861.18	721.23	332.88	1,144.66	528.30
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,738.28	802.28	27.17	12.54	1,765.45	814.82	721.23	332.88	1,044.22	481.95
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,259.76	1,042.97	192.66	88.92	2,452.42	1,131.89	1,779.13	821.14	673.29	310.75
	Family Coverage (FT) w/Delta Care Dental HMO	2,259.76	1,042.97	40.19	18.55	2,299.95	1,061.52	1,779.13	821.14	520.82	240.38
	Family Coverage (Ben PT) w/Delta Dental Premier	2,259.76	1,042.97	192.66	88.92	2,452.42	1,131.89	721.23	332.88	1,731.19	799.01
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,259.76	1,042.97	40.19	18.55	2,299.95	1,061.52	721.23	332.88	1,578.72	728.64

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Orange, San Diego, and Imperial.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Blue Shield Trio HMO (Orange only)										
Employee Only	Employee only (FT) w/Delta Dental Premier	810.24	373.96	74.10	34.20	884.34	408.16	721.23	332.88	163.11	75.28
	Employee only (FT) w/Delta Care Dental HMO	810.24	373.96	15.12	6.98	825.36	380.94	721.23	332.88	104.13	48.06
	Employee only (Ben PT) w/Delta Dental Premier	810.24	373.96	74.10	34.20	884.34	408.16	721.23	332.88	163.11	75.28
	Employee only (Ben PT) w/Delta Care Dental HMO	810.24	373.96	15.12	6.98	825.36	380.94	721.23	332.88	104.13	48.06
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,620.48	747.91	127.61	58.90	1,748.09	806.81	1,342.43	619.58	405.66	187.23
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,620.48	747.91	27.17	12.54	1,647.65	760.45	1,342.43	619.58	305.22	140.87
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,620.48	747.91	127.61	58.90	1,748.09	806.81	721.23	332.88	1,026.86	473.94
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,620.48	747.91	27.17	12.54	1,647.65	760.45	721.23	332.88	926.42	427.58
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,106.62	972.29	192.66	88.92	2,299.28	1,061.21	1,779.13	821.14	520.15	240.07
	Family Coverage (FT) w/Delta Care Dental HMO	2,106.62	972.29	40.19	18.55	2,146.81	990.84	1,779.13	821.14	367.68	169.70
	Family Coverage (Ben PT) w/Delta Dental Premier	2,106.62	972.29	192.66	88.92	2,299.28	1,061.21	721.23	332.88	1,578.05	728.33
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,106.62	972.29	40.19	18.55	2,146.81	990.84	721.23	332.88	1,425.58	657.96
	Health Net Salud y Mas HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	684.77	316.05	74.10	34.20	758.87	350.25	721.23	332.88	37.64	17.37
	Employee only (FT) w/Delta Care Dental HMO	684.77	316.05	15.12	6.98	699.89	323.03	721.23	332.88	-21.34	-9.85
	Employee only (Ben PT) w/Delta Dental Premier	684.77	316.05	74.10	34.20	758.87	350.25	721.23	332.88	37.64	17.37
	Employee only (Ben PT) w/Delta Care Dental HMO	684.77	316.05	15.12	6.98	699.89	323.03	721.23	332.88	-21.34	-9.85
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,369.54	632.10	127.61	58.90	1,497.15	690.99	1,342.43	619.58	154.72	71.41
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,369.54	632.10	27.17	12.54	1,396.71	644.64	1,342.43	619.58	54.28	25.05
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,369.54	632.10	127.61	58.90	1,497.15	690.99	721.23	332.88	775.92	358.12
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,369.54	632.10	27.17	12.54	1,396.71	644.64	721.23	332.88	675.48	311.76
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	1,780.40	821.72	192.66	88.92	1,973.06	910.64	1,779.13	821.14	193.93	89.51
	Family Coverage (FT) w/Delta Care Dental HMO	1,780.40	821.72	40.19	18.55	1,820.59	840.27	1,779.13	821.14	41.46	19.14
	Family Coverage (Ben PT) w/Delta Dental Premier	1,780.40	821.72	192.66	88.92	1,973.06	910.64	721.23	332.88	1,251.83	577.77
	Family Coverage (Ben PT) w/Delta Care Dental HMO	1,780.40	821.72	40.19	18.55	1,820.59	840.27	721.23	332.88	1,099.36	507.40

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Orange, San Diego, and Imperial.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Kaiser Permanente California HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	904.95	417.67	74.10	34.20	979.05	451.87	721.23	332.88	257.82	118.99
	Employee only (FT) w/Delta Care Dental HMO	904.95	417.67	15.12	6.98	920.07	424.65	721.23	332.88	198.84	91.77
	Employee only (Ben PT) w/Delta Dental Premier	904.95	417.67	74.10	34.20	979.05	451.87	721.23	332.88	257.82	118.99
	Employee only (Ben PT) w/Delta Care Dental HMO	904.95	417.67	15.12	6.98	920.07	424.65	721.23	332.88	198.84	91.77
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,809.90	835.34	127.61	58.90	1,937.51	894.24	1,342.43	619.58	595.08	274.65
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,809.90	835.34	27.17	12.54	1,837.07	847.88	1,342.43	619.58	494.64	228.30
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,809.90	835.34	127.61	58.90	1,937.51	894.24	721.23	332.88	1,216.28	561.36
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,809.90	835.34	27.17	12.54	1,837.07	847.88	721.23	332.88	1,115.84	515.00
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,352.87	1,085.94	192.66	88.92	2,545.53	1,174.86	1,779.13	821.14	766.40	353.72
	Family Coverage (FT) w/Delta Care Dental HMO	2,352.87	1,085.94	40.19	18.55	2,393.06	1,104.49	1,779.13	821.14	613.93	283.35
	Family Coverage (Ben PT) w/Delta Dental Premier	2,352.87	1,085.94	192.66	88.92	2,545.53	1,174.86	721.23	332.88	1,824.30	841.98
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,352.87	1,085.94	40.19	18.55	2,393.06	1,104.49	721.23	332.88	1,671.83	771.61
	PERS Gold PPO										
Employee Only	Employee only (FT) w/Delta Dental Premier	799.44	368.97	74.10	34.20	873.54	403.17	721.23	332.88	152.31	70.30
	Employee only (FT) w/Delta Care Dental HMO	799.44	368.97	15.12	6.98	814.56	375.95	721.23	332.88	93.33	43.08
	Employee only (Ben PT) w/Delta Dental Premier	799.44	368.97	74.10	34.20	873.54	403.17	721.23	332.88	152.31	70.30
	Employee only (Ben PT) w/Delta Care Dental HMO	799.44	368.97	15.12	6.98	814.56	375.95	721.23	332.88	93.33	43.08
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,598.88	737.94	127.61	58.90	1,726.49	796.84	1,342.43	619.58	384.06	177.26
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,598.88	737.94	27.17	12.54	1,626.05	750.48	1,342.43	619.58	283.62	130.90
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,598.88	737.94	127.61	58.90	1,726.49	796.84	721.23	332.88	1,005.26	463.97
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,598.88	737.94	27.17	12.54	1,626.05	750.48	721.23	332.88	904.82	417.61
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,078.54	959.33	192.66	88.92	2,271.20	1,048.25	1,779.13	821.14	492.07	227.11
	Family Coverage (FT) w/Delta Care Dental HMO	2,078.54	959.33	40.19	18.55	2,118.73	977.88	1,779.13	821.14	339.60	156.74
	Family Coverage (Ben PT) w/Delta Dental Premier	2,078.54	959.33	192.66	88.92	2,271.20	1,048.25	721.23	332.88	1,549.97	715.37
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,078.54	959.33	40.19	18.55	2,118.73	977.88	721.23	332.88	1,397.50	645.00
	PERS Platinum PPO										
Employee Only	Employee only (FT) w/Delta Dental Premier	1,151.50	531.46	74.10	34.20	1,225.60	565.66	721.23	332.88	504.37	232.79
	Employee only (FT) w/Delta Care Dental HMO	1,151.50	531.46	15.12	6.98	1,166.62	538.44	721.23	332.88	445.39	205.56
	Employee only (Ben PT) w/Delta Dental Premier	1,151.50	531.46	74.10	34.20	1,225.60	565.66	721.23	332.88	504.37	232.79
	Employee only (Ben PT) w/Delta Care Dental HMO	1,151.50	531.46	15.12	6.98	1,166.62	538.44	721.23	332.88	445.39	205.56
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	2,303.00	1,062.92	127.61	58.90	2,430.61	1,121.82	1,342.43	619.58	1,088.18	502.24
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	2,303.00	1,062.92	27.17	12.54	2,330.17	1,075.46	1,342.43	619.58	987.74	455.88
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	2,303.00	1,062.92	127.61	58.90	2,430.61	1,121.82	721.23	332.88	1,709.38	788.94
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	2,303.00	1,062.92	27.17	12.54	2,330.17	1,075.46	721.23	332.88	1,608.94	742.59
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,993.90	1,381.80	192.66	88.92	3,186.56	1,470.72	1,779.13	821.14	1,407.43	649.58
	Family Coverage (FT) w/Delta Care Dental HMO	2,993.90	1,381.80	40.19	18.55	3,034.09	1,400.35	1,779.13	821.14	1,254.96	579.21
	Family Coverage (Ben PT) w/Delta Dental Premier	2,993.90	1,381.80	192.66	88.92	3,186.56	1,470.72	721.23	332.88	2,465.33	1,137.84
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,993.90	1,381.80	40.19	18.55	3,034.09	1,400.35	721.23	332.88	2,312.86	1,067.47

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Orange, San Diego, and Imperial.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)
	Sharp Performance Plus HMO (San Diego county only)										
Employee Only	Employee only (FT) w/Delta Dental Premier	833.24	384.57	74.10	34.20	907.34	418.77	721.23	332.88	186.11	85.90
	Employee only (FT) w/Delta Care Dental HMO	833.24	384.57	15.12	6.98	848.36	391.55	721.23	332.88	127.13	58.68
	Employee only (Ben PT) w/Delta Dental Premier	833.24	384.57	74.10	34.20	907.34	418.77	721.23	332.88	186.11	85.90
	Employee only (Ben PT) w/Delta Care Dental HMO	833.24	384.57	15.12	6.98	848.36	391.55	721.23	332.88	127.13	58.68
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,666.48	769.14	127.61	58.90	1,794.09	828.04	1,342.43	619.58	451.66	208.46
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,666.48	769.14	27.17	12.54	1,693.65	781.68	1,342.43	619.58	351.22	162.10
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,666.48	769.14	127.61	58.90	1,794.09	828.04	721.23	332.88	1,072.86	495.17
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,666.48	769.14	27.17	12.54	1,693.65	781.68	721.23	332.88	972.42	448.81
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,166.42	999.89	192.66	88.92	2,359.08	1,088.81	1,779.13	821.14	579.95	267.67
	Family Coverage (FT) w/Delta Care Dental HMO	2,166.42	999.89	40.19	18.55	2,206.61	1,018.44	1,779.13	821.14	427.48	197.30
	Family Coverage (Ben PT) w/Delta Dental Premier	2,166.42	999.89	192.66	88.92	2,359.08	1,088.81	721.23	332.88	1,637.85	755.93
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,166.42	999.89	40.19	18.55	2,206.61	1,018.44	721.23	332.88	1,485.38	685.56
	United Healthcare Signature Alliance HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	837.88	386.71	74.10	34.20	911.98	420.91	721.23	332.88	190.75	88.04
	Employee only (FT) w/Delta Care Dental HMO	837.88	386.71	15.12	6.98	853.00	393.69	721.23	332.88	131.77	60.82
	Employee only (Ben PT) w/Delta Dental Premier	837.88	386.71	74.10	34.20	911.98	420.91	721.23	332.88	190.75	88.04
	Employee only (Ben PT) w/Delta Care Dental HMO	837.88	386.71	15.12	6.98	853.00	393.69	721.23	332.88	131.77	60.82
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,675.76	773.43	127.61	58.90	1,803.37	832.32	1,342.43	619.58	460.94	212.74
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,675.76	773.43	27.17	12.54	1,702.93	785.97	1,342.43	619.58	360.50	166.38
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,675.76	773.43	127.61	58.90	1,803.37	832.32	721.23	332.88	1,082.14	499.45
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,675.76	773.43	27.17	12.54	1,702.93	785.97	721.23	332.88	981.70	453.09
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,178.49	1,005.46	192.66	88.92	2,371.15	1,094.38	1,779.13	821.14	592.02	273.24
	Family Coverage (FT) w/Delta Care Dental HMO	2,178.49	1,005.46	40.19	18.55	2,218.68	1,024.01	1,779.13	821.14	439.55	202.87
	Family Coverage (Ben PT) w/Delta Dental Premier	2,178.49	1,005.46	192.66	88.92	2,371.15	1,094.38	721.23	332.88	1,649.92	761.50
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,178.49	1,005.46	40.19	18.55	2,218.68	1,024.01	721.23	332.88	1,497.45	691.13
	United Healthcare Signature Harmony HMO										
Employee Only	Employee only (FT) w/Delta Dental Premier	792.65	365.84	74.10	34.20	866.75	400.04	721.23	332.88	145.52	67.16
	Employee only (FT) w/Delta Care Dental HMO	792.65	365.84	15.12	6.98	807.77	372.82	721.23	332.88	86.54	39.94
	Employee only (Ben PT) w/Delta Dental Premier	792.65	365.84	74.10	34.20	866.75	400.04	721.23	332.88	145.52	67.16
	Employee only (Ben PT) w/Delta Care Dental HMO	792.65	365.84	15.12	6.98	807.77	372.82	721.23	332.88	86.54	39.94
Employee + 1 Dependent	Employee (FT) + 1 Dependent w/Delta Dental Premier	1,585.30	731.68	127.61	58.90	1,712.91	790.57	1,342.43	619.58	370.48	170.99
	Employee (FT) + 1 Dependent w/Delta Care Dental HMO	1,585.30	731.68	27.17	12.54	1,612.47	744.22	1,342.43	619.58	270.04	124.63
	Employee (Ben PT) + 1 Dependent w/Delta Dental Premier	1,585.30	731.68	127.61	58.90	1,712.91	790.57	721.23	332.88	991.68	457.70
	Employee (Ben PT) + 1 Dependent w/Delta Care Dental HMO	1,585.30	731.68	27.17	12.54	1,612.47	744.22	721.23	332.88	891.24	411.34
Employee + Family	Family Coverage (FT) w/Delta Dental Premier	2,060.89	951.18	192.66	88.92	2,253.55	1,040.10	1,779.13	821.14	474.42	218.96
	Family Coverage (FT) w/Delta Care Dental HMO	2,060.89	951.18	40.19	18.55	2,101.08	969.73	1,779.13	821.14	321.95	148.59
	Family Coverage (Ben PT) w/Delta Dental Premier	2,060.89	951.18	192.66	88.92	2,253.55	1,040.10	721.23	332.88	1,532.32	707.22
	Family Coverage (Ben PT) w/Delta Care Dental HMO	2,060.89	951.18	40.19	18.55	2,101.08	969.73	721.23	332.88	1,379.85	636.85

CITY OF SAN CLEMENTE MEDICAL & DENTAL RATES EFFECTIVE 1/1/2023

FOR COUNTIES OF: Orange, San Diego, and Imperial.

Coverage Tier	Plans	Medical Cost per Month	Medical Cost Per Pay Period	Dental Cost per Month	Dental Cost Per Pay Period	Total Monthly Cost for Medical & Dental	Total Cost Per Pay Period For Medical & Dental	Monthly Cafeteria Plan Allowance for Medical & Dental Only (City Contribution)	Cafeteria Plan Allowance for Medical & Dental Only Per Pay Period (City Contribution)	Employee Cost Per Month	Employee Cost Per Pay Period (Bi-Wkly)

Notes:

1) Employees can opt out of dental coverage and receive the balance of the Cafeteria Plan amount.
2) Married Employees opt out rebate: FT $80.77/pay period, Benefited Part-Time.
3) Rebate for opting out of Medical for FT Employees is $300/month ($138.46 biweekly); for Benefited Part-time $100/month ($46.15 biweekly). Employee must remain in Vision.
4) Rebate for opting out of medical and dental for FT Employees is $315.93/month ($145.81 biweekly); for Benefited Part-time $115.93/month ($53.50 biweekly). Employee must remain in Vision.
5) There are 26 pay periods per year.
6) The rates listed on this sheet do not include the VSP Vision costs as these are City-paid and not part of the Cafeteria Plan.